

DSRIP Optional Next Steps

DSRIP Learning Collaborative

September 15, 2016

2:00 PM – 4:00 PM

New Jersey Department of Health (NJDOH)

✓ Review these Performance Measurement Documents

	Purpose	Objective
✓ NJ DSRIP Performance Measurement Databook	To outline collection, reporting, measure specification criteria and incentive impact related to every DSRIP measure collected and reported (Chart/EHR and MMIS).	To ensure clear, consistent performance measurement instructions through a single reference document.
✓ Appendix A – Value Sets (Codes and Medications)	To provide diagnosis and procedure code tables for associated measures. These codes were made available by the measure steward.	To minimize hospital effort to collect the measure requirements and ensure consistent usage.
✓ Appendix B – Planned Readmission Codes	To provide code tables for associated readmission measures.	To minimize hospital effort to collect the measure requirements and ensure consistent usage.
✓ Appendix C - Programming Assumptions	To provide specific detail related to requirements and assumptions made to program the measures which use the MMIS claims administration data that will be reported on the behalf of hospitals.	To increase the transparency of programming steps performed on the behalf of hospitals.
✓ NJ DSRIP Standard Reporting Workbook	To provide a workbook that is utilized by all hospitals to submit required reported data for both Stage III and Stage IV Chart/EHR measures.	To ensure consistent hospital and partner reporting so that it may be readily compiled and analyzed for trending clinical improvement and incentive payment tracking.

PATIENT-LEVEL REPORTING

Patient Smith - Attribution Example:

Provider	Visits (unweighted)	Weighted Visits	Attribution Category
Category 1: Hospital-based Clinics			
Hospital- based Clinic A	4	1.2	Hospital-based Clinic
Category Total	4	1.2	
Category %	5.19%	2.57%	Hospital-based Clinic
Category 2: Emergency Departments			
Hospital ED A	31	19.7	ED
Hospital ED B	31	19.3	ED
Hospital ED C	8	4.4	ED
Category Total	70	43.4	
Category %	90.91%	92.93%	ED
Category 3: Community-based Reporting Partners			
Community-based Partner	0	0	Project Partner
Category Total	0	0	
Category %	0.00%	0.00%	Project Partner
Category 4: All other providers; No attribution			
FQHC	2	1.4	Non-Hospital
Physician	1	0.7	Non-Hospital
Category Total	3	2.1	
Category %	3.90%	4.50%	Non-Hospital
Overall Total	77	46.7	

Patient Smith was seen at multiple provider entities throughout the 2014/2015 period. Attribution assigned the patient to Hospital A.

Hospital A is conducting “Project 6 - Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions.”

Hypothetically assume:

Assume this patient is 18 years of age.

Assume an FQHC, identified as a reporting partner for Hospital A, is routinely providing care to the patient for his Type 1 diabetes.

Assume he had one routine visit to a physician for a check-up.

Attribution and Measure Implication Examples:

- Mr. Smith **will be** in the attribution population for all MMIS-calculated measures for Hospital A.
- Mr. Smith **should be** in the attribution population for all chart/EHR measures for Hospital A upon proper patient-matching.
- Mr. Smith **will be** in the denominator that captures outpatient information about well-child visits because he meets age criteria. (DSRIP #27 – Children and Adolescents’ Access to Primary Care Practitioner)
- Mr. Smith does not have a cardiac condition and therefore **will not** be in the Stage 3 measures that require a cardiac condition.
- Mr. Smith **will be** in the denominator for any measure that captures data inclusive of patients aged 18 years of age with diabetes.
- Mr. Smith **will be** in the denominator for measures that captures data regarding any inpatient admission due to the diabetes condition. (DSRIP # 36 – Diabetes Short-Term Complications Admission Rate)
- Mr. Smith **should be** identified by the FQHC project partner and available to be included in the denominator for any Chart-based measure that captures data regarding the treatment of the diabetes condition. (DSRIP #30 – Comprehensive Diabetes Care: LDL-C Control <100 mg/DL) (Sampling applies.)

Report Example: Numerator = 6; Denominator = 78; Result = 7.7%

Count of Denominator Patients equal to **Denominator** total in Results Calculation.

Count of Numerator Patients equal to **Numerator** total in Results Calculation.

	Denominator Eligible Cou	Recipient ID Source	Recipient Medicaid ID (Original)	Recipient Medicaid ID (Current)	Patient Account Number	SSN	Recipient Last Name	Recipient First Name	Recipient Middle Initial	Date of Birth	Gender	Denominator Inclusion	Denominator Inclusion Location	Numerator Event Inclusion	Numerator Event Inclusion Provider	Numerator Eligible Cou
1	1	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	1
2	2	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	2
3	3	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	3
4	4	Medicaid	Number	Number	Number	XXX-XX-Number	Smith	Patient	A	1/1/1998	F	5/1/2013	Hospital A	5/20/2013	Out of Network	4
5	5	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS	Hospital A	5
6	6	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS	Hospital A	6
7	7	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
8	8	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
9	9	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
10	10	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
11	11	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
12	12	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
13	13	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
14	14	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
15	15	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
16	16	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
17	17	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
18	18	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
19	19	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
20	20	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
21	21	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
22	22	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
23	23	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
24	24	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
25	25	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
26	26	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
27	27	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
28	28	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
29	29	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
30	30	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		

Report Example: Numerator = 6; Denominator = 78; Result = 7.7%

Count of Denominator Patients equal to **Denominator** total in Results Calculation.

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	Denominator Eligible Cou	Recipient ID Source	Recipient Medicaid ID (Original)	Recipient Medicaid ID (Current)	Patient Account Number	SSN	Recipient Last Name	Recipient First Name	Recipient Middle Initial	Date of Birth	Gender	Denominator Inclusion	Denominator Inclusion Location	Numerator Event Inclusion	Numerator Event Inclusion Provider	Numerator Eligible Cou
1																
50	49	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
51	50	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
52	51	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
53	52	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
54	53	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
55	54	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
56	55	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
57	56	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
58	57	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
59	58	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
60	59	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
61	60	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
62	61	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
63	62	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
64	63	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
65	64	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
66	65	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
67	66	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
68	67	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
69	68	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
70	69	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
71	70	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
72	71	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
73	72	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
74	73	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
75	74	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
76	75	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
77	76	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
78	77	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			
79	78	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network			

Report Example: Numerator = 6; Denominator = 78; Result = 7.7%

Any patient that has had ALL Denominator and Numerator eligible events at a provider **other than Hospital A** will be marked as Hidden. Hospital A will not receive this patient-level data.

Denominator Eligible Cou	Recipient ID Source	Recipient Medicaid ID (Original)	Recipient Medicaid ID (Current)	Patient Account Number	SSN	Recipient Last Name	Recipient First Name	Recipient Middle Initial	Date of Birth	Gender	Denominator Inclusion	Denominator Inclusion Location	Numerator Event Inclusion	Numerator Event Inclusion Provider	Numerator Eligible Cou
1	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	1
2	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	2
3	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	3
4	Medicaid	Number	Number	Number	XXX-XX-Number	Smith	Patient	A	1/1/1998	F	5/1/2013	Hospital A	5/20/2013	Out of Network	4
5	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS	Hospital A	5
6	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS	Hospital A	6
7	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
8	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
9	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
10	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
11	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
12	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
13	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
14	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
15	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
16	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
17	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
18	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
19	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
20	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
21	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
22	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
23	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
24	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
25	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
26	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
27	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
28	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
29	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
30	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		

Hidden

Report Example: Numerator = 6; Denominator = 78; Result = 7.7%

Any patient that has had at least 1 event at Hospital A, in either the Denominator or Numerator, will be populated.

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1	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	1
2	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	2
3	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	3
4	Medicaid	Number	Number	Number	XXX-XX-Number	Smith	Patient	A	1/1/1998	F	5/1/2013	Hospital A	5/20/2013	Out of Network	4
5	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS	Hospital A	5
6	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS	Hospital A	6
7	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
8	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
9	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
10	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
11	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
12	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
13	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
14	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
15	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
16	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
17	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
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19	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
20	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
21	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
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23	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
24	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
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26	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
27	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
28	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
29	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
30	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		

Denominator
Event only

Report Example: Numerator = 6; Denominator = 78; Result = 7.7%

Any patient that has had at least 1 event at Hospital A, in either the Denominator or Numerator, will be populated.

Denominator Eligible Cou	Recipient ID Source	Recipient Medicaid ID (Original)	Recipient Medicaid ID (Current)	Patient Account Number	SSN	Recipient Last Name	Recipient First Name	Recipient Middle Initial	Date of Birth	Gender	Denominator Inclusion	Denominator Inclusion Location	Numerator Event Inclusion	Numerator Event Inclusion Provider	Numerator Eligible Cou
1	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	1
2	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	2
3	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	3
4	Medicaid	Number	Number	Number	XXX-XX-Number	Smith	Patient	A	1/1/1998	F	5/1/2013	Hospital A	5/20/2013	Out of Network	4
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7	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
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30	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		

Both Numerator
and Denominator
Events

Report Example: Numerator = 6; Denominator = 78; Result = 7.7%

Any patient that has had at least 1 event at Hospital A, in either the Denominator or Numerator, will be populated.

Denominator Eligible Cou	Recipient ID Source	Recipient Medicaid ID (Original)	Recipient Medicaid ID (Current)	Patient Account Number	SSN	Recipient Last Name	Recipient First Name	Recipient Middle Initial	Date of Birth	Gender	Denominator Inclusion	Denominator Inclusion Location	Numerator Event Inclusion	Numerator Event Inclusion Provider	Numerator Eligible Cou
1	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	1
2	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	2
3	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Hidden	Out of Network		Out of Network	3
4	Medicaid	Number	Number	Number	XXX-XX-Number	Smith	Patient	A	1/1/1998	F	5/1/2013	Hospital A	5/20/2013	Out of Network	4
5	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS	Hospital A	5
6	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS	Hospital A	6
7	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
8	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
9	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
10	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
11	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
12	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
13	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
14	Charity Care	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
15	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
16	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
17	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
18	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
19	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
20	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
21	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
22	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
23	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
24	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
25	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
26	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
27	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
28	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
29	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		
30	Medicaid	Number	Number	Number	XXX-XX-Number	Last Name	First Name	Initial	DOB	Gender	DOS	Hospital A	DOS		

Denominator Events Only

- Hospital submits Request for Information (RFI) with required data elements.
- Turn around time may be 7-14 days.
- Reports requested will be prioritized.
- Hospitals will not be held to the 30 day appeal/reconsideration deadline until receipt of data requested through the RFI process.

APPEAL/RECONSIDERATION

Appeal/Reconsideration Process Objectives

- ✓ Request for Information Process
- ✓ Appeal/Reconsideration Process
 1. Initiating an appeal request
 2. Submitting an appeal request
 3. Reasons for appeal request
- ✓ Timelines
 - Hospital
 - Department
 - CMS

✓ Request for Information Process

REQUEST FOR INFORMATION (RFI)

- ❖ The RFI is specifically for review or planning purposes and does not initiate an Appeal/Reconsideration
- ❖ The RFI form is located <https://dsrip.nj.gov/Home/Resources>
- ❖ RFIs will be given a high priority for response
 - Please note that some requests will have a short response time while others may take up to 14 days
 - Hospitals will not be held to the 30 day appeal/reconsideration deadline until receipt of data requested through the RFI process.

NJDSRIP REQUEST FOR INFORMATION (RFI)

(please complete all sections)

HOSPITAL INFORMATION

Hospital Name: Select Hospital

Project Name: Select Project Name

Submitted By: Enter Submitted By Name

Submission Date: Click here to enter a date.

Medicaid Provider ID: Click here to enter text.

Documents Submitted: ☐ Yes ☐ No

Point of Contact: Click here to enter text.

Contact Information: Enter Phone and email

Please complete to submit a Request for Information (RFI).

Shaded areas allow the user to select from a list or enter information.

If additional space is needed, attachments may be submitted via FTP

REQUESTED INFORMATION

In order to expedite each RFI, please ensure your request includes a detailed description. Please list each item separately in the areas below.

This request for information is specifically for review or planning purposes and does not initiate a Reconsideration/Appeal. Please see the Reconsideration form located on the NJDSRIP [website](#).

+ If the request is measure specific, please include the below information:

Measure Name	Measure DSRI #	Performance Period	Comment

Request for measure specific information should be listed in this table.

Enter description or explanation of request in the below text field.

Click here to enter text.

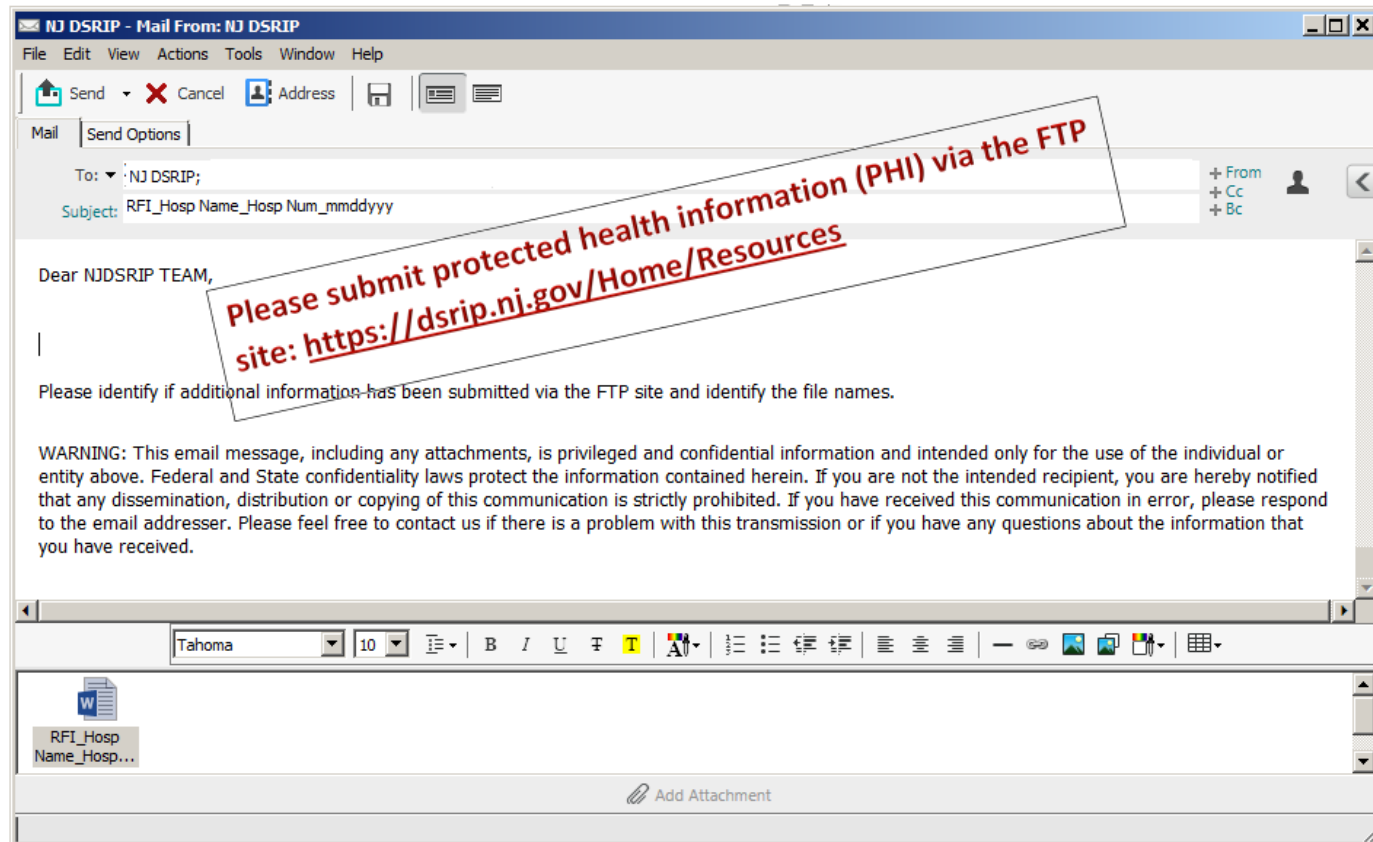
The shaded area provides free text to describe requested information in detail.

- ✓ Please complete the above Request for Information (RFI) and submit to the NJDSRIP@mslc.com.
- ✓ As a reminder: please do not send documents that contain protected health information (PHI) with the form.



This RFI is specifically for review or planning purposes and does not initiate a Reconsideration/Appeal. Please see the Reconsideration/Appeal form located on the NJDSRIP [website](#).

- ✓ Submit the RFI form to the NJDSRIP@mslc.com
- ✓ Submit RFI information containing PHI via the FTP site <https://dsrip.nj.gov/Home/Resources>



✓ Appeal/Reconsideration Process

Steps to initiate an appeal/reconsideration



Step 1. Initiating an appeal request

Complete the Appeal/Reconsideration form to initiate a request

- a. Appeal Form located on the NJDSRIP website - <https://dsrip.nj.gov/Home/Resources>



Sec I. Hospital Information Sec II. Appeal Area

NJDSRIP Appeal/Reconsideration Form
(please complete all sections)

Sec. I. HOSPITAL INFORMATION:

Hospital Name:

Submission Date:

Medicaid Provider ID:

Project Name:

Documents Attached: ☐ Yes ☐ No

Submitted By: Contact Information:

Executive Level: Project Point of Contact:

Sec. II. RECONSIDERATION REASON

Each request for reconsideration will be reviewed for validity and completion upon submission. Please ensure your request includes a detailed description of the identified variance and supporting documentation for each area.

The reconsideration process is available to address reporting and/or computational discrepancies within the 2015 Performance Period. Please select the areas to be included in the request from the below options. (Please note: only the areas identified in this request will be included in the reconsideration.)

Area	Included in appeal	Reporting	Computation	Comments
Databook/Value Sets	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
Chart/EHR Measure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
MMS Measure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	

NJDSRIP Request for Reconsideration

pg. 1

Sec III. Databook, Measure information

Sec. III. RECONSIDERATION-SUPPORT INFORMATION

are related to the identified areas in section I. The submitted information should include information pointing to the area of reconsideration.

III.1 DATABOOK - RECONSIDERATION

Measure ID	Databook Page #	Value Set ID (Appendix A)	Comments

Information as possible to describe the noted discrepancy. Additional documents may be attached.

SRIP@msk.com

ected health information (PHI) with the form.

III.2 CHART/EHR MEASURE RECONSIDERATION

Performance Period	Numerator	Denominator	Result	Comment

Information as possible to describe the noted discrepancy. Additional documents may be attached. Chart/EHR measures must include the abstraction process used for reporting.

Reconsideration

pg. 2

RECONSIDERATION

Result	Comment

pg. 3

NJDSRIP Appeal/Reconsideration Form

(please complete all sections)

Sec. I. HOSPITAL INFORMATION:

Hospital Name: [Select Hospital](#)

Submission Date: [Click here to enter a date.](#)

Medicaid Provider ID: [Click here to enter text.](#)

Project Name: [Select Project Name](#)

Documents Submitted: ☐ Yes ☐ No

Submitted By: [Enter Submitted By Name](#) Contact Information: [Enter Phone and email](#)

Executive Level
Project Representative: [Click here to enter text.](#)

Project Point of
Contact: [Click here to enter text.](#)

Section I. must be completed to submit a Request for Reconsideration.

Shaded areas allow the user to select from a list or enter information. Please ensure this information is completed.

Sec. II. RECONSIDERATION REASON

Each request for reconsideration will be reviewed for validity and completion upon submission. Please ensure your request includes a detailed description of the identified variance and supporting documentation for each area.

The reconsideration process is available to address reporting and/or computational discrepancies within the 2015 Performance Period. Please select the areas to be included in the request from the below options. (Please note: only the areas identified in this request will be included in the reconsideration.)

Area	Included in appeal	Reporting	Computation	Comments
Databook/Value Sets	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
Chart/EHR Measure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
MMIS Measure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	

Select the box for each area that is included in the request for reconsideration.

Please Note: areas selected will determine scope of the reconsideration.

Sec. III. RECONSIDERATION-SUPPORT INFORMATION

The following sections are related to the identified areas in section I. The submitted information should include detailed and specific information pointing to the area of reconsideration.

III.1 DATABOOK - RECONSIDERATION

Databook

Measure Name	Measure DSRIP ID	Databook Page #	Value Set ID (Appendix A)	Comments

Information related to data specifications or value sets should be identified in this area.

The shaded area below is available for detailed information.

Please provide as much information as possible to describe the noted discrepancy. Additional information may be provided as an attachment.

[Click here to enter text.](#)

III.2 CHART/EHR MEASURE RECONSIDERATION

Chart/EHR Measures

Measure Name	Measure DSRIP #	Performance Period	Numerator	Denominator	Result	Comments

Information related to chart/EHR measures should be identified in this area.

The shaded area below is available for detailed text information.

Please provide as much information as possible to describe the noted discrepancy. Additional documents may be provided as an attachment. Chart/EHR measures must include the abstraction process used for reporting.

[Click here to enter text.](#)

III.3 MMIS MEASURE RECONSIDERATION

MMIS Measures

Measure Name	Measure DSRIP #	Performance Period	Numerator	Denominator	Result	Comment

Information related to MMIS measures should be identified in this area.

The shaded area below is available for detailed text information.

Please provide as much information as possible to describe the noted discrepancy. Additional documents may be provided as an attachment.

Click here to enter text.

Step 2. Submitting the appeal/reconsideration request form

- a. ensure the appropriate sections of the appeal/reconsideration form is completed
- b. submit the form via email to NJDSRIP@mslc.com
 - ❖ As a reminder: please do not send documents that contain protected health information (PHI) with the form.



NJ DSRIP - Mail From: NJ DSRIP

File Edit View Actions Tools Window Help

Send Cancel Address

Mail Send Options

To: NJ DSRIP;

Subject: Appeal Request_Hosp Name_Hosp Num_mmddyyyy

Dear NJDSRIP TEAM,

Please identify if additional information has been submitted via the FTP site and identify the file names.

WARNING: This email message, including any attachments, is privileged and confidential information and intended only for the use of the individual or entity above. Federal and State confidentiality laws protect the information contained herein. If you are not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please respond to the email addresser. Please feel free to contact us if there is a problem with this transmission or if you have any questions about the information that you have received.

Tahoma 10 B I U T A

Apael Request_H...

Add Attachment

Please submit protected health information (PHI) via the FTP site: <https://dsrip.nj.gov/Home/Resources>

Step 3. Submitting supporting documentation per Secure File Transfer (SFTP) located <https://dsrip.nj.gov/Home/Resources>



Step 4. Reasons for an appeal request

- Please see the NJ DSRIP Forfeiture of Payments and Appeals document located <https://dsrip.nj.gov/Home/Resources>

The reconsideration process is available to address reporting and/or computational discrepancies within the 2015 Performance Period. Please select the areas to be included in the request from the below options. (Please note: only the areas identified in this request will be included in the reconsideration.)

Area	Included in appeal	Reporting	Computation	Comments
Databook/Value Sets	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
Chart/EHR Measure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
MMIS Measure	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	



✓ Timelines

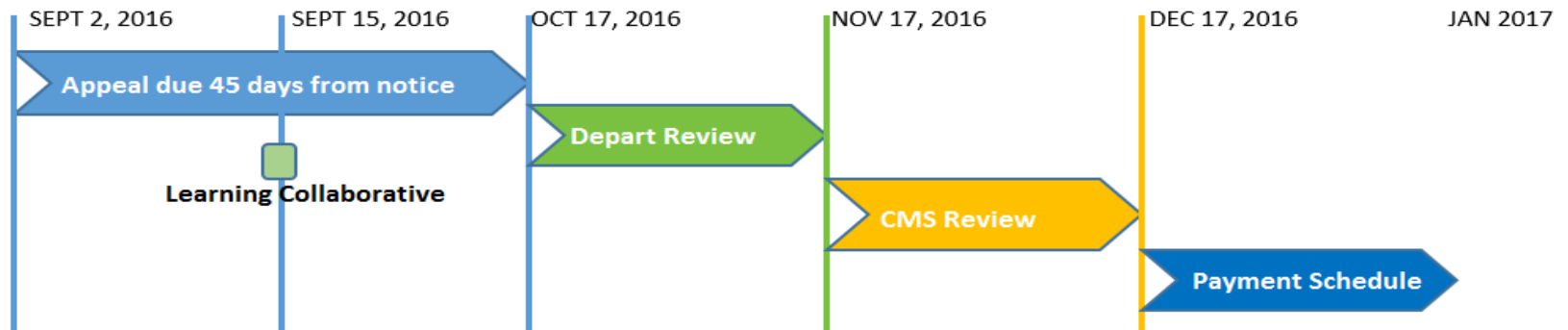
Upon notification by the Department that a performance measure has not been met and the associated payment has not been earned, a hospital shall have 30 calendar days from the date of notification to submit a written appeal request to the Commissioner of Health. (NJ DSRIP Forfeiture of Payments and Appeals)

- ✓ To allow for 30 calendar days from this learning collaborative, the due date for appeal requests is October 17, 2016.
- ✓ 30 day turn-around clock will begin only after the hospital receives their RFI data.

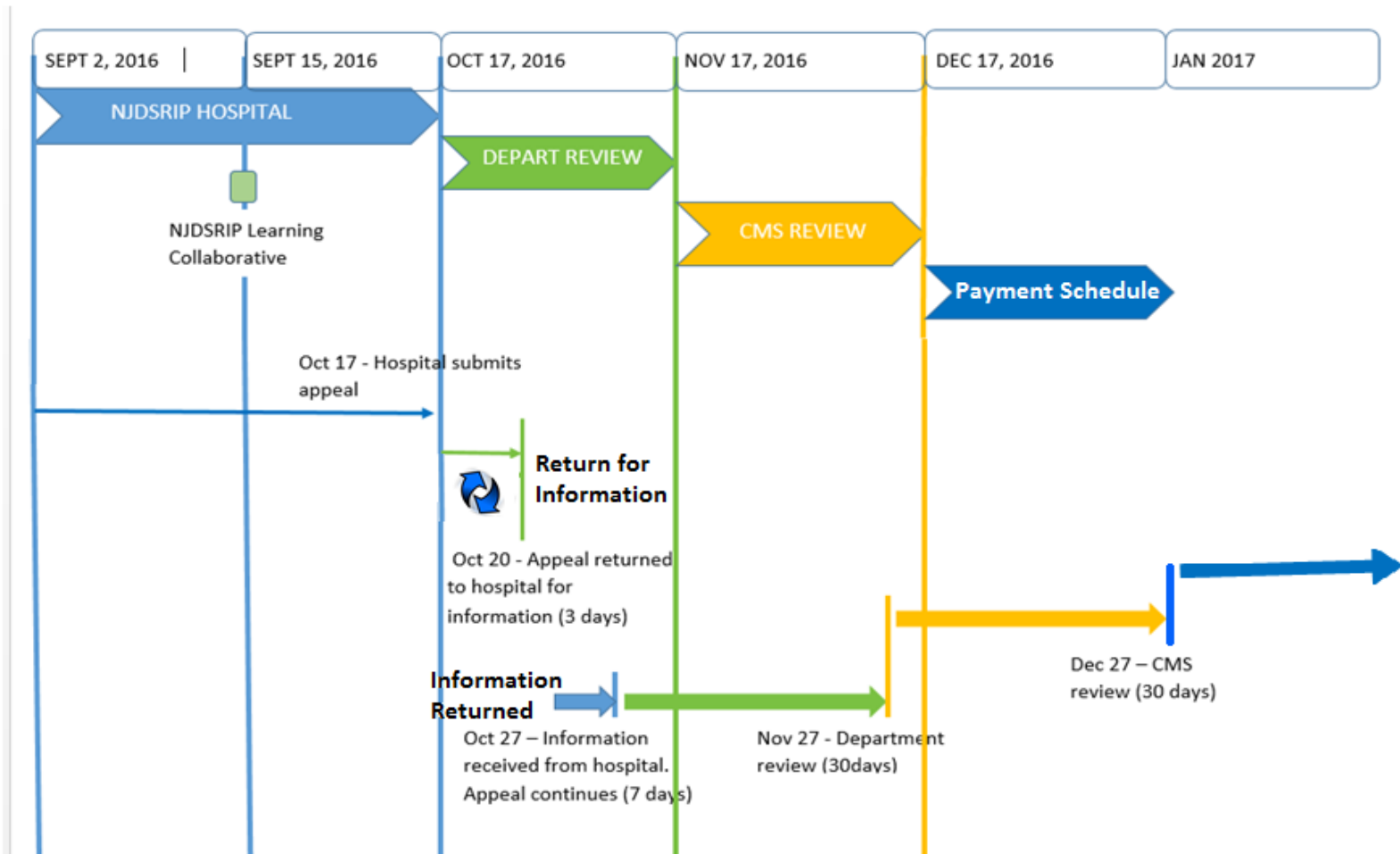


Timeline without delays or write-backs

- Hospital
- Department
- CMS



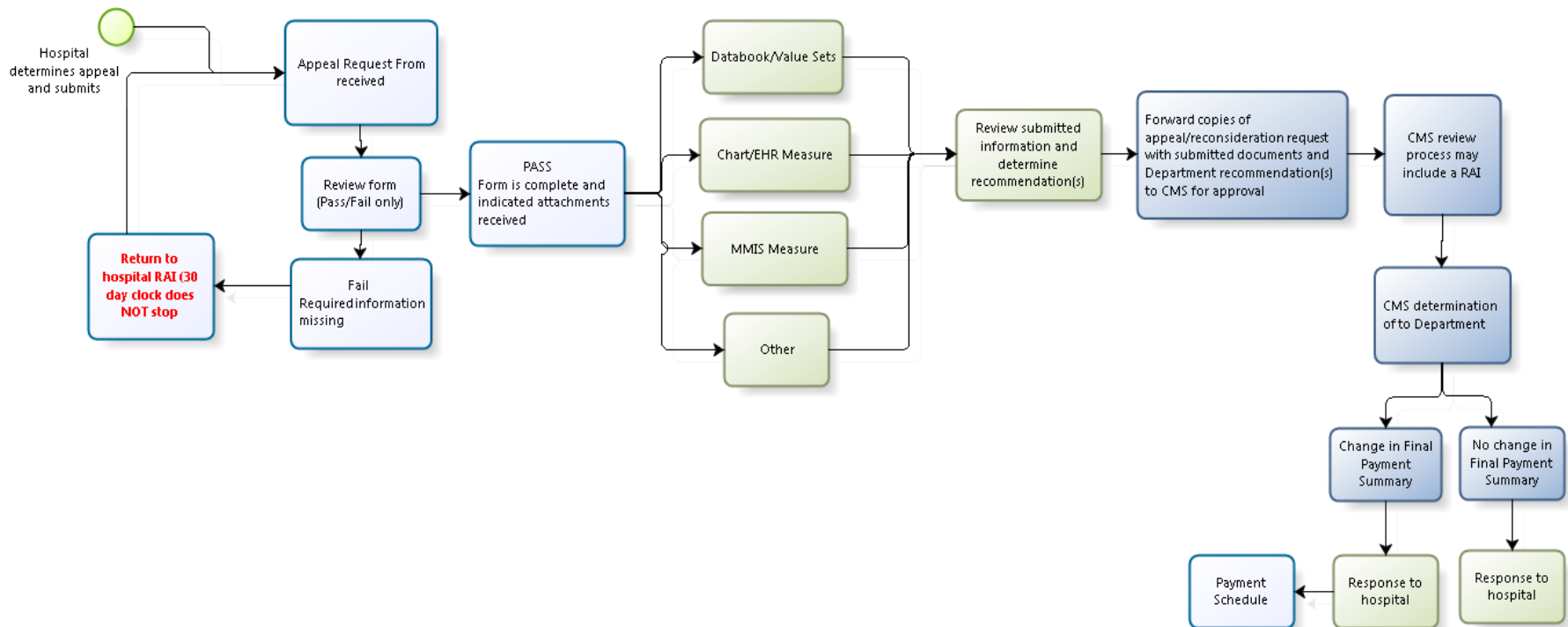
Timeline with one delay for information



Hosp - submit form/attachments

Depart - review

CMS - review and approve



1. Complete the appeal/reconsideration form and
2. Submit form to initiate a request
 - a. Appeal Form located on the NJDSRIP website - <https://dsrip.nj.gov/Home/Resources>
 - b. Email - NJDSRIP@MSLC.COM
Please do not submit PHI via email
3. Provide supporting Information - Attachments
 - a. FTP Site - <https://dsrip.nj.gov/Home/Resources>
4. Timeline
 - a. Request
 - b. Department
 - c. CMS

Activity	Timeline
DY5 Q2 Progress Reports	Due October 31, 2016
DY5 Q3 Progress Reports	Due January 31, 2017
Patient Rosters	Expected October 2017
1 st Semi-annual Performance Measurement	Due January 31, 2017
DY5 Q4 Progress Reports	Due April 30, 2017
Patient Rosters	Expected February 2017
2 nd Semi-annual Performance Measurement	Due April 30, 2017

GROUP DISCUSSION

THANK YOU



- ✓ Sign an attendance sheet before leaving today
- ✓ Complete and email the survey for this LC meeting, located on the NJ DSRIP website, no later than **September 23, 2016**